Special Series

Future of Health Care Reform
The Effects on Physicians

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The scope, timing, and effects of the health care reforms that many informed persons advocate cannot be specified in detail because before they become operational they must still be negotiated in three different arenas—Congress, state legislatures, and the marketplace. Because the introduction of major reforms will affect the operations of the extant health care system, additional reforms will be required, the nature and extent of which cannot be predicted until initial reforms have been implemented and the results examined. Because of this series of chain reactions, any serious effort to sketch the future of health care reforms and, more particularly, to focus on how they are likely to affect physicians, must be more speculative than definitive.

Despite these inherent difficulties, some clarifications can be made by identifying four major areas where reforms are likely to be introduced in the near or mid-term:

- Providing the entire citizenry with health insurance coverage,
- Moderating the additional dollars flowing into the health care sector,
- Changing the organization and delivery of health care services, and
- Constraining capital investments.

Other targets for early reform can be identified, but any listing would overlap, to a greater or lesser degree, these areas. The more important challenge is to explore how the reforms within these areas are likely to affect our present health care system and, more particularly, how physicians are likely to practice in the future.

Universal Coverage

President Clinton has emphasized not once but many times since his September 1993 address to Congress on health care reform that he is open to all sorts of negotiations with Congress about the specifics of the legislative program that they will develop and pass as long as universal coverage is included. When one recognizes that this country spends about 40% more per capita than the next-highest spending nations for health care and that the other advanced countries have provided coverage for many years to their entire population, the time is long overdue for the United States to take action on universal coverage.

Such action will increase the demand for physician services and thereby have a favorable effect on the earnings of the medical profession. There is a second reason to view universal coverage as a boost to physicians: they will no longer have to explain to themselves, the public, and the uninsured why they avoid treating indigent patients.

The President's proposal for universal coverage is linked to a specified package of essential services that is modeled after the health benefits currently provided by Fortune 500 companies. Although this is a good package of benefits, the planned coverage will be less extensive than that now enjoyed by a minority of those with full coverage.

One of the striking features of our health care system has been the proclivity of the medical profession to undertake any and all diagnostic and therapeutic procedures that appear to hold promise for their patients without concern for the cost/benefit of successive medical interventions. In the new era of severe dollar constraints, the perpetuation of such an open-ended patient care strategy will not be sustainable. Physicians have protested repeatedly about the growing constraints on their clinical freedom, but the odds favor a still more contentious environment if universal coverage brings with it, as it must, a specification of the services that the system will and will not pay for.

A related observation: although informal rationing has always been part and parcel of the health care system in the United States, the criteria used to decide who will have access to more costly procedures such as a heart or liver transplant have usually been obscured. But well-to-do patients have always enjoyed preferred access. In the face of universal coverage with accompanying dollar constraints, the American people will be under increasing pressure to confront the implications of overt rather than sub rosa rationing. Such a challenge will require the active participation of physicians, who are in the best posi-

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tion to assess the therapeutic benefits of costly and risky procedures. But decisions affecting the allocation of scarce medical resources in a democracy can never be left solely to the medical profession.

Moderating the Flow of New Dollars Into the System

The urgency for slowing dollar expenditures increases. The United States cannot much longer tolerate adding new funds for health care at a rate two to three times as fast as the growth of its gross domestic product. The trillion-dollar level for health care outlays will be breached in 1994, and current projections point to a 2-trillion dollar figure by 2000 or shortly thereafter. The dollar flow into the health care sector must be slowed. We are, however, still far from an agreement about how this objective is to be achieved. President Clinton has recommended that Congress cut back substantially on future appropriations for Medicare and also increase the copayments of the more affluent elderly for Medicare B premiums. Others look to reducing or eliminating federal subsidies for health insurance, which total over $70 billion a year, to help constrain consumer demand. Still others advocate an intensified reliance on competitive forces by building up strong regional health alliances that would be able to bargain more effectively with physicians and hospitals.

What are the likely consequences of a reduced rate of dollar inflow into the health care system? First, fewer total health care dollars will mean fewer dollars to compensate the ever-increasing supply of practicing physicians. Inadequate attention has been paid to the fact that between 1960 and today, the physician supply per 100,000 has increased from 140 to 250, an increase of almost 80%. Despite this, physician earnings have substantially outpaced the increase in earnings of a typical worker. The earnings of physicians in 1992 after expenses but before taxes averaged $164,000. This paradoxical increase between the growth in the number of physicians at the same time that their earnings increased was possible only because of the large amounts of new money entering the health care system. In 1965, on the eve of the implementation of Medicare and Medicaid, total national health care expenditure in constant dollars was approximately $150 billion. By the end of 1994, there will have been more than a sixfold increase to $1 trillion.

Any serious effort to slow the flow of total dollars into the health care system is likely to force individuals and families to cover a higher proportion of total expenditures through out-of-pocket payments, which is likely to have a moderating effect on physicians' earnings.

The more dollar-constrained the health care system becomes, the more likely it is that in a reduced demand for physician services, greater reliance on mid-level health personnel, and added payer resistance to physician fee increases will result, foreshadowed by the recently enacted resource-based relative-value-scale reimbursement approach introduced by Medicare.

Some counterforces are likely to lead to an increased demand for physician services if and when universal coverage is implemented, but it is unlikely that even in the face of an expanded total demand for health care services, physicians' earnings will continue to increase at the same rate as in the past. The more likely outcome is a retardation in the rate of growth of physicians' earnings.

Organization and Delivery Reforms

There is growing recognition that the private health insurance industry has contributed to the large number of persons without insurance and the unease experienced by a still larger number that they may lose their insurance coverage if they change jobs. The Health Insurance Association of America, cognizant of the growing criticisms levied against the industry and traumatized by the recent resignation of several of its largest members, proposed at the end of 1992 that it would cooperate with the federal government to assure universal coverage. This action represents a reversal of the 40-year strategy during which the private insurance companies splintered the insurance pool to improve their profitability by pursuing risk management tactics directed at identifying and covering only the best risks.

Reacting to the growing trend of employers to self-insure—about 60% of all employees are in employer self-insured plans—such large insurance companies as Cigna, Aetna, Metropolitan, and Prudential have developed managed care networks, through shared-risk contracts with large employers in which they identify preferred physicians and hospitals that offer quality health care at a competitive price. A correlate of such risk contracts is the willingness of physicians and hospitals to participate in accountability systems that such risk contracting requires.

Another consequence of these managed care arrangements is the changes introduced in the reimbursement patterns for physician services. In the place of fee-for-service, physicians who join such networks may accept capitation, go on salary, or agree to still other modes of reimbursement that differ substantially from fee-for-service.

A likely concomitant of the changes under way in the organization and delivery of health care, especially in an era of reduced rates of total dollar outlays, will be the rapid decline in the number of physicians who practice solo or in small groups. These practice arrangements, though having many advantages, also have high costs and limited market power. Larger group practices hold the promise of substantial savings in support personnel, medical equipment, rent, and other office expenditures.

Capital Investments

The fourth major area in which longer-range reforms are likely to be initiated in the near and middle term relates to capital investments. These affect the number and types of physicians trained; the size of the hospital plant, equipment, and personnel staffing ratios; and the trends for biomedical research and development, by both the federal government and industry.

The expansion of the physician supply in the 1960s

and 1970s was undertaken with little attention to the costs of enlarging the educational infrastructure and even less to the substantial financial consequences for the health care system. Had we increased over the past three decades the total supply of physicians by 40% instead of 80%, our 1994 outlays for medical care might have been $300 billion lower.

Currently the American Medical Assocation, the American Association of Medical Colleges, the Committee on Graduate Medical Education, the Physician Payment Review Commission, and still other governmental and advisory bodies are sending the same signals: contain the future supply of physicians, decrease the relative number of specialists, and pay more attention to linking physicians to underserved populations.

With an increasing number of students graduating from medical school with an average debt of $70,000 or higher, it should not prove difficult for the federal government alone or in association with the states to put effective arrangements in place whereby the debts of young physicians are canceled for several years of service among underserved rural and inner-city groups.

The federal government is also likely to take early action to modify the conditions governing graduate medical education funding so that more support is provided for residency training for generalists rather than for specialists. The more difficult challenge will be for states, particularly those with several medical schools, to merge or close their smaller and less effective schools.

In the short span between 1985 and 1992, national support for health research and development increased from $13.6 billion to $28.1 billion, with industry's share growing so rapidly that it overtook the federal government's contribution of $11.6 billion.

We must assume that if major reforms to constrain future health care spending are introduced and implemented in the near and middle term, such efforts will inevitably be reflected in some moderation of new investments in research and development. The likely effect on development is the focus of the industry's concern. Hospitals facing tightened budgets will move more slowly to purchase the latest (and more expensive) pieces of equipment. In turn, the medical supply companies are likely to moderate their research and development expenditures.

But there are additional forces at work that are likely to slow the purchases of expensive new equipment. Medicare has taken some selective actions both to resort to technology assessment before authorizing reimbursement and to restrict expensive procedures such as heart transplants to a limited number of medical centers.

A more controlled and constrained financial health care environment will underpin the continuing shift of treatment to ambulatory care settings that will be reflected sooner or later in a notable decline in the number of acute care hospitals. The combination of constrained dollars and fewer inpatients points to a substantial shrinkage in hospital capacity in the decade ahead. Such a shrinkage will have an important effect on patients' access to care and on the future earnings of physicians. The closing of a local hospital is often a prelude to the relocation of physicians or to difficulties in recruiting physicians to replace those who retire or die.

A Look to the Future

Brief attention should be directed to a few of the more important consequences of health care reform on the future shape and functioning of the US health care system, with particular attention on how the reforms are likely to affect physicians.

An increasing proportion of all patients are likely to become members of large insured groups that will enter into long-term relations with designated physicians and hospitals. Enrollees will be under strong financial and other pressures to seek treatment from designated providers whose payments will depend little, if at all, on a fee-for-service arrangement. If this is the wave of the future, physicians will find it necessary to join such large group arrangements where they will probably have considerably less clinical and economic freedom than they presently enjoy under a solo or small group practice based on fee-for-service. The fact remains that the best—perhaps the only—prospect of constraining the total costs of US health care involves substantial alterations in how physicians currently practice, how they are paid, and how much they are permitted to earn.

Clearly such reforms affecting the financing and delivery of health care services as have been outlined here will also have important effects on patients' choices and their satisfaction with the medical care they receive. The scale and scope of the choices available to them as to their principal physician and the specialists they may want or need to consult will be largely determined by the health care plan to which they belong. Those with more disposable income, particularly the wealthy, will probably encounter little difficulty in maintaining the high degree of freedom of choice that they now enjoy in selecting physicians and in securing expensive modes of treatment.

In 1974 the United States resorted to federal and state governmental planning in order to control capital investments in hospitals and costly equipment, but the legislation was permitted to lapse after a few years because of the cumbersome machinery needed to implement "certificates of need." The fact that the nation dropped the regulation of capital investments in the past does not preclude a second and broader attempt in the future to place a lid on total health care outlays (global budgeting), an objective that will also necessitate controlling capital investments.

It is almost certain that decision making regarding the number, types, and deployment of physicians in the future will see enlarged roles for both the federal and state governments. Neither universal coverage nor cost controls can be achieved without more effective planning and deployment of health care personnel, particularly physicians, who are and will continue to be key to the delivery of effective health care services to the American people.